

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2009
FORM APPROVED
LTC Residents Protection B NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING SEP 22 2009 B. WING Director's Office		(X3) DATE SURVEY COMPLETED C 08/24/2009
NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE 19940		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from August 17, 2009 through August 24, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred (100). The survey sample totaled twenty (20) residents which included a review of seventeen (17) active and three (3) closed residents' clinical records. There was a subsample of seven (7) residents for observation and interviews.	F 000	The plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Delmar Nursing & Rehabilitation Center agrees with the allegations and citations listed on the statement of deficiencies. Delmar Nursing & Rehabilitation Center maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Delmar Nursing & Rehabilitation Center written credible allegation of compliance. By submitting this plan of correction, Delmar Nursing & Rehabilitation Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish and standard of care, contract, obligation, or position and Delmar Nursing & Rehabilitation Center reserves the rights to raise all possible contentions and defenses in any civil or criminal claim action or proceeding.		
F 164 SS=B	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information	F 164			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Brenda C. Coley - Moody, NHA

9/21/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	<p>Continued From page 1</p> <p>contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that four (R9, R15, R17 and SSR6) residents were provided with personal privacy. Findings include:</p> <p>1. R9 was observed on 8/18/09 at 11:04 AM and 8/19/09 at 9:32 AM to be receiving a bed bath from an aide (E21). On both occasions the door to the room was partially open and the privacy curtain was not drawn all the way around the bed. R9 was in view of staff entering the room and the other residents living in the room. On 8/18/09 one of the two roommates exited the room wheeling past the end of R9's bed and conversing with the aide while the the resident was exposed.</p> <p>2. On 8/19/09 at 2:30 PM an outside call was received for R15 at the unit two nurses station. Staff went to the resident's room and told him he had a call at the desk. The resident took the phone call at the nurses station in view of others. Staff at the nurses station did not offer R15 the use of the portable phone located at the station or ask him if he wanted privacy.</p> <p>3. On 8/18/09 at 11:15 am R17 was speaking on the portable phone in the hall outside nursing station 3; which provided no auditory privacy. The resident was heard telling the party that she was speaking to that she couldn't talk on the phone in</p>	F 164	<p>The curtain was replaced in R9 room with a longer curtain that encircles the entire bed.</p> <p>R15, R17, and SSR6 have been informed of their right to make private phone calls and have been given a working cordless phone when they have calls to use in their room or the break room.</p> <p>A sweep of all privacy curtains in the facility has been completed to assure that all curtains pull completely around the entire resident bed.</p> <p>All phones have been tested to assure that they work in all resident rooms.</p> <p>Housekeeping will conduct weekly rounds on the privacy curtains to assure they encircle the entire resident area. Maintenance will check phones for adequate reception weekly. Staff have been educated on providing privacy for residents during care and for telephone conversations.</p> <p>Findings will be reported to the QA committee monthly and monitored therein.</p>	10/19/2009	

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F 164	Continued From page 2 her room because the portable phone did not work there. On 8/19/09 at approximately 11:00 am the surveyors tested the portable phone in R17's room and found that although a call could be placed, the static on the line impacted the quality of the reception.	F 164			
F 278	4. On 8/20/09 at approximately 11:30 am, unit 2 nursing manager (E11) received a phone call for SSR6. E11 asked the staff to bring SSR6 to the nurse's station because he had a phone call. SSR6 was brought to the nurse's station and was handed the phone; this location lacked auditory privacy. SSR6 was not asked if he would like to take the call in private or to use the portable phone. During interview with SSR6 on 8/20/09 at 2:30 pm he stated that he prefers to have calls in private and it is easier for him to take calls in his room on the portable phone.	F 278			
SS=0 R48	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is				

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F 278	Continued From page 3 subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that one (R8) out of 20 sampled residents had an accurate assessment of bladder function. Findings include: Cross refer F315 example #1. R8 had a decline in bladder continence that was not reflected on the annual MDS dated 8/5/09. The previous assessment dated 5/5/09 indicated the resident was usually continent of bladder. Review of the nurse aide documentation supported this assessment. The 8/5/09 assessment indicated that R8 was occasionally incontinent of bladder. Review of the nurse aide documentation indicated the resident was frequently incontinent of bladder.	F 278	R8's MDS was corrected before submission on 8/21/09 An audit was conducted on 8/20/09 to determine the accuracy of incontinence documentation on the MDS. MDS coordinator has reviewed incontinence coding in the RAI manual. Education of the CNA's for coding incontinence is in progress to be completed on 10/27/09 10 % of resident records will be audited quarterly to determine accuracy of the MDS coding for incontinence with results reported to the QA committee for continued monitoring.	8/20/09 8/20/09 10/27/09 ongoing
F 309 GS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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F 309	Continued From page 4 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure two residents (R7, SSR3) out of 20 sampled residents received their medication according to the physician's plan of care. Findings include: 1. R7 had physician orders for Timoptic 0.5% one drop in each eye daily and Alphagan 0.15% one drop both eyes daily for Glaucoma. A review of the medication administration record (MAR) revealed the Timoptic drop was scheduled for 8AM and the Alphagan drop for 8PM. During a medication pass on 08/18/09 at 7:50 AM, Nurse E2 administered 2 drops each eye of the 8PM scheduled drug, Alphagan. E1 administered the incorrect number of drops and the incorrect scheduled medication. 2. SSR3 had a physician's order for Aspirin 81 mg. take 4 tablets (324mg) by mouth daily for Coronary Artery Disease. During a medication pass on 08/19/09, administering nurse, E3 gave one Aspirin 81 mg. to SSR3 instead of the intended dosage of four. Upon reconciliation of the medication pass, E3 acknowledged the medication error and gave SSR3 the remaining three doses Aspirin.	F 309	R7's physician was notified of the medication administered. Medication times were changed to enable the administration of the proper medications for the day. SSR3's medications were administered as ordered prior to completion of the med pass. Medication pass audits have been conducted on the two licensed nursing staff identified in the 2567 to ascertain regulatory compliance in medication administration. Mar's have been highlighted to denote administration requiring more than one pill at a time. 25% of licensed staff will be audited on medication administration each quarter by the DON or designee to determine regulatory compliance. Results of the audit will be conducted to the QA committee and monitored therein for compliance.	10/19/2009	
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315			

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F 315	<p>Continued From page 5</p> <p>indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to implement a plan to restore bladder function for two (R8 and R9) out of 20 sampled residents. Findings include:</p> <p>1. R8 was admitted to the facility on 8/19/08 and was assessed as being continent of bladder. The resident's Minimum Data Set (MDS) assessment dated 5/5/09 indicated the resident was usually continent of bladder. Review of the ADL (activity of daily living) flow sheets completed by the aides for May and June 2009 revealed the resident was continent of urine.</p> <p>Review of the July 2009 ADL sheets revealed that starting on 7/5/09 the resident was having incontinent episodes daily on the day and evening shifts. On 7/28/09 the resident was diagnosed and treated for a urinary tract infection. Review of the August 2008 ADL sheet for the first 20 days of the month revealed incontinence of bladder on 56 out of 60 shifts.</p> <p>A quarterly bowel and bladder assessment was completed on 8/11/09 and was incorrectly documented that R8 was continent of urine when in fact he had been frequently incontinent of</p>	F 315	<p>R8 had a new bladder assessment completed. Resident had a 3 day voiding diary completed and was placed on a toileting plan. R9 completed a 3 day voiding trial and was placed on prompted voiding.</p> <p>An audit of all current residents bladder assessments has been completed to determine accuracy and appropriateness of interventions.</p> <p>The bladder assessment policy has been reviewed and updated accordingly. Education has been provided to licensed nursing staff on accurately completing bladder assessments and appropriate interventions based on their scores.</p> <p>Quarterly audits will be conducted on all bladder assessments completed during this time period by the DON or designee to determine the accuracy of assessment and the appropriateness of interventions.</p> <p>Findings of the audit will be reported to the QA committee and monitored for compliance therein.</p>	10/19/2009	

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F 315	<p>Continued From page 6</p> <p>bladder. No further assessment of this change of bladder status was documented. There were no care plan approaches added to address this change in bladder function. The resident was not identified as being on a toileting plan.</p> <p>An interview with the unit manager (E11) on 8/20/09 at 2:50 PM confirmed that the facility failed to identify the change in bladder continence and failed to implement an assessment and treatment plan for the incontinence.</p> <p>2. R9 was admitted to the facility 3/6/09 post hospitalization from a right below the knee amputation. The resident was assessed as being totally incontinent of bowel and bladder on the initial MDS dated 3/10/09.</p> <p>The facility bowel and bladder assessment dated 3/9/09 scored a 15 which indicated the resident was a poor candidate for a toileting schedule or retraining. The next assessment dated 6/11/09 scored a 13 which indicated the resident was a candidate for timed voiding. No further assessment or care planning approaches were added to address this change.</p> <p>An interview on 8/20/09 at 2:40 PM with the nurse who completed the 6/11/09 assessment (E22) revealed that she did not feel the resident was mentally able to participate in a toileting plan and did not do any further assessments. An interview on 8/20/09 at 3 PM with the aide who usually cares for R9 on the dayshift (E21) revealed that she takes the resident to the bathroom about three times a day. At times the resident will ask her to take him to the bathroom. She further revealed that R9 had urinated and had a bowel movement on the toilet that day after requesting</p>	F 315			

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F 315	Continued From page 7 to go to the bathroom.	F 315			
F 323 SS=D	<p>There was no evidence that the facility attempted to assess and/or implement a plan to restore normal bladder function.</p> <p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that the facility failed to ensure that the resident environment remained free of accident hazards and failed provide adequate supervision to prevent 2 elopements from the facility for one resident (R10) out of twenty sampled residents. Findings include:</p> <p>R10 was admitted to the facility on 3/21/07 with diagnoses which included: dementia, stroke and heart failure. A care plan dated 1/14/08 identified R10 as having wandering behavior and at risk for elopement care plan interventions included the use of a wanderguard (a wanderguard is an electronic bracelet that will activate a door alarm, when the resident attempts to exit the doorway). The care plan was evaluated on 2/17/09 and stated the resident had no attempts to elope; however a psychiatric evaluation dated 1/16/09 stated R7 had periods of confusion and an attempted elopement and was being monitored</p>	F 323	<p>Resident was returned to the building without harm.</p> <p>An audit was conducted of all residents on wanderguards were having them checked each shift and documented on the TAR.</p> <p>The wanderguard and elopement policies were reviewed , updated and reinforced with staff. A policy for securing vendor entrances and deliveries was implemented and staff educated on the same.</p> <p>The policy for incident investigation was reviewed with administrative staff Licensed staff was in-serviced on documentation of behaviors and incidents.</p> <p>All elopement incidents will be reviewed during rounds by the nursing administrative team for completion, accuracy and appropriate interventions.</p> <p>Monthly audits will be conducted of the residents TAR that have wanderguards for documentation of shift checks.</p> <p>Results will be reported to the QA committee and will be monitored therein</p>	10/19/2009	

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F 323	<p>Continued From page 8</p> <p>and had a wanderguard on. Physician's orders dated 2/27/09 and 4/09 stated " Wanderguard, monitor for changes in mentation and elopement attempts. "</p> <p>On 4/1/09 R10 had a wanderguard on and eloped twice through a rear door that was protected by a wanderguard alarm and also had a second door alarm that would activate if anyone opened the door. According to interview with E13 (Administrator) on 8/24/09 she stated that on 4/1/09 at approximately 9:15 am a food truck was making a delivery at the facility, the door alarm was disarmed by a staff person in order for delivery person to prop the door open. When the delivery man made a trip outside he saw R10 standing by the truck, he brought her back in and notified E19 (food service director). The driver continued to unload his supplies and approximately 20 minutes later R10 exited the building again. The driver alerted an activity staff member (E20) and she brought R10 back into the building. Review of a statement from E20 stated the driver told her R10 had been out once before.</p> <p>During review of the facility incident report and interviews with E13, E14 (DON), and E16 (ADON), R10 was brought back into the building unharmed; however there were no immediate interventions to secure the unalarmed door or to provide supervision for R10 to prevent a second elopement. The facility incident report does not identify the second elopement and there is no determination of the status of the wanderguard door alarm. E16 stated R10's bracelet alarm was checked and it was functioning properly. During interview with the maintenance man (E18) on 8/24/09 at 10:00 am he stated he replaced the electronic panel for the wanderguard door alarm</p>	F 323			

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F 323	Continued From page 9 on 4/8/09. Review of the facility policy for elopement stated that if a resident has a wanderguard; the wanderguard is checked each shift and marked on the TAR (treatment administration record). Review of the March 2009 TAR revealed the staff documented each shift that the wanderguard was checked. Review of the April 2009 TAR revealed the staff did not document for the entire month that the wanderguard was checked each shift. Review of R10's behavior flow sheet dated 4/1/09 incorrectly stated she had no wandering behavior on that day. The facility staff failed to identify the hazards associated with the wanderguard system and failed to ensure that the wanderguard door alarms were functioning. The facility failed to identify and evaluate the risk of disarming secured doors and failed to implement interventions to reduce the risk of a resident exiting an unsecured door. The facility failed to implement immediate interventions after one successful elopement and failed to provide adequate supervision or a safe environment to prevent R10 from eloping two times in a brief period of time. In addition the facility failed to monitor wanderguard bracelets per their policy, failed to perform an accurate comprehensive investigation of the elopements and failed to document wandering and elopement behaviors.	F 323			
F 365 SS=D	483.35(d)(3) FOOD Each resident receives and the facility provides food prepared in a form designed to meet individual needs.	F 365			

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F 365	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and record review it was determined that the facility failed to ensure two (R14 and SSR7) out of 20 sampled residents received meals that met their individual needs. Findings include: 1. R14 had a list of food dislikes that included cauliflower. Observation of lunch on 3/17/09 revealed that the resident had cauliflower on her tray. She stated that she did not like cauliflower. The resident's meal ticket that was on the tray listed cauliflower as a dislike. Neither the kitchen staff plating the food nor the aide delivering the food noticed the resident was being served a food item that she would not eat. 2. SSR7 had a list of food dislikes that included broccoli. Lunch observation on 8/19/09 revealed that the resident had broccoli on her tray. The resident's meal ticket that was on the tray listed broccoli as a dislike. Neither the kitchen staff plating the food nor the aide delivering the food noticed the resident was being served a food item that she would not eat.	F 365	R14 and SSR7 have had individual consultations with dietary manager to assure their likes and dislikes are accurately - documented and the dietary manager has completed random checks on each of their food trays to assure they are receiving correct selections. Resident preference information has been updated and highlighted on all dietary cards. Dietary staff and CNA's have been educated to determine that the preferences are correct on each tray served. Random tray audits will be conducted monthly by the dietary manager or designee on 10% of all residents. Results of the audit will be reported to the QA committee and monitored therein for compliance.		10/19/2009
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425			

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F 425	<p>Continued From page 11</p> <p>administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: Payne, Howard Based on record review and interview, it was determined that the facility's pharmaceutical services failed to identify and obtain clarification of a physician's order for the contraindicated use of a medication and failed to deliver routine medications in a timely manner for one resident (R7) out of 20 sampled residents. Findings include:</p> <p>1. R7 was admitted to the facility on 07/29/09 with a physician's order for Lidoderm Patch 5% apply one patch to both knees every 12 hours for bilateral knee replacement pain. Interpretation of this order according to the unit manager, E11 on 08/18/09 at 10:10 AM, indicates two patches should be applied twice a day providing 24 hour coverage for pain. E1 further stated that Lidoderm patches are not intended for use of more than 12 hours per day and that the physician's order was incorrect and would be clarified with the physician.</p> <p>Endo Pharmaceuticals, manufacturer of the Lidoderm patch, confirms E11 statement by published information that "Lidoderm patches</p>	F 425	<p>R7's Lidoderm patch order was clarified with the physician and pharmacy and rewritten. Opana was given at the time of delivery on 7/30/09.</p> <p>An audit was completed to determine that all medications are available and that they are being administered per indication.</p> <p>Education for licensed staff has been completed on the narcotic ordering process and what to do if medications are not delivered in a timely fashion.</p> <p>Interim narcotic availability has been reviewed by the DON and updated, adding numbers and types of narcotics available.</p> <p>Unit managers have been instructed to review medication orders on admission to determine accurate clinical indication and usage and to notify the pharmacy of any concerns.</p> <p>Random audits of 10% of residents will be conducted by the DON or designee monthly to determine medication availability and correct indication usage.</p> <p>Findings will be reported to the QA committee and monitored therein.</p>		10/19/2009

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F 425	Continued From page 12 should be worn for no more that 12 hours a day. Additionally, "applying the patches for a longer time could cause serious reactions." Although review of the Medication Administration Record revealed the patches were administered once every twelve hours as indicated, pharmacy services failed to identify and obtain clarification of the physician's order that is contraindicated with the use of the Lidoderm patch. 2. R7 was admitted to the facility on 07/29/09 at approximately 5:15 PM with a physician's order for Calcium with vitamin D BID (twice a day), Opana 20 mg. every 12 hours, Nexium 40 mg. BID, Reglan 5 mg. before meals and Colace 100 mg. BID. Review of the facility policy for procuring routine medications stated that if medication is needed before the next scheduled delivery, the pharmacist must be notified of the exact time the medication is needed. According to interview with the Director of Nursing (E14) on 8/24/09 at 7:30 am stated that there was a pharmacy delivery at approximately midnight on 7/29/09 and another delivery at approximately 6 am on 7/30/09. The pharmacy was not notified of the time the medications were needed. R7 did not receive the evening dose of the aforementioned medications on 7/29/09 or the 8 am dose of Opana on 7/30/09.	F 425			
F 469 SS=E	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469			

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F 469	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to have an effective pest control program for flies. Findings include:</p> <p>Observations made daily during the survey in all resident living areas revealed flies. Flies were seen landing on residents and their food trays.</p> <p>Review of the pest control sighting log indicated that flies were noted on all units of the building by staff in the months prior to this survey. The pest control company has implemented a fly control program for the facility and in a letter, dated 07/02/09, indicated that the exterior dumpster had been moved from behind the building to a lot across the street.</p> <p>Additionally, the facility management, E13 (Administrator) and E23 (corporate administration), indicated that a vestibule area will be created in the front lobby area, at the entry doors, to assist in managing the pest problem. During survey, two oscillating floor fans on the exterior of the front entrance of the building were being used to address the entry of flies at that location. Past corrections for pest control problems with flies had included the addition of air curtains and other pest deterrent devices at the back and side doors. The entrance door did not have an effective deterrent device to prevent the entry of flies into the facility. This entrance door is heavily used by residents, visitors and staff.</p> <p>Residents and staff both confirmed the presence of flies throughout the survey.</p>	F 469	<p>A review of all recommendations made by the present pest control company was completed by the administrator and the maintenance department to ensure that all recommendations are being followed.</p> <p>Bird feeders were removed from near the building to prevent the presence of feed attracting flies to the building.</p> <p>Plans are under way for a vestibule area at the main entrance which will diminish the possibility of the entrance of flies to the building.</p> <p>A new pest control company has been contracted to begin October 1, 2009</p> <p>The presence of pests will be monitored during daily maintenance rounds.</p> <p>Findings will be reported to the QA committee and monitored therein.</p>		10/19/2009

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F 497 SS=E	<p>483.75(e)(8) REGULAR IN-SERVICE EDUCATION</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the Certified Nursing Aides (C.N.A.'s) personnel files and in-service records, it was determined that the facility failed to provide regular in-service training for seven out of seven C.N.A's reviewed. Findings include:</p> <ol style="list-style-type: none"> 1. C.N.A., E4, had 9.75 hours of in-service on record for the prior anniversary year from date of hire. 2. C.N.A., E5, had 9.00 hours of in-service on record for the prior anniversary year from date of hire. 3. C.N.A., E6, had 7.00 hours of in-service on record for the prior anniversary year from date of hire. 4. C.N.A., E7, had 3.75 hours of in-service on 	F 497	<p>The seven CNA's identified in the review are in compliance with the mandatory training hours.</p> <p>Inservice regulations have been reviewed and incorporated into company policy and orientation process by the Director of Staff Development.</p> <p>A new training log has been implemented by the Director of Staff Development to allow for more precise tracking of training hours.</p> <p>CNA's will be regularly scheduled to attend an education day during their anniversary month to ensure hours are captured during the review period.</p> <p>Inservice hours will be audited quarterly for compliance by the Human Resource director. Findings will be reported to the QA committee and monitored therein.</p>	10/19/2009	

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F 497	Continued From page 15 record for the prior anniversary year from date of hire. 5. C.N.A., E8, had 4.50 hours of in-service on record for the prior anniversary year from date of hire. 6. C.N.A., E9, had 8.50 hours of in-service on record for the prior anniversary year from date of hire. 7. C.N.A., E10, had no record of any hours of in-service on record for the prior anniversary year from date of hire.	F 497			
F 514 SS=D	483.75(I)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Cross refer F425 Based on record review and interview, it was determined that the facility failed to ensure an accurate clinical record was maintained for one resident (R7) out of 20 residents sampled. Findings include:	F 514	R7's order was clarified with the physician and re-transcribed on the physicians order sheet and the MAR. An audit was conducted of all admissions for the last 60 days to determine the accuracy of transcription on admission orders. Licensed staff have been inserviced on transcribing orders on admissions and the monthly POS turnover. Unit Managers will audit all new admissions for order accuracy. Random monthly audits of 10% of residents' POS will be completed by the DON or designee to ensure accuracy of transcription. Findings will be reported to the QA committee and monitored therein.	10/19/2009	

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F 514	Continued From page 16 R7 was transferred to the facility from an acute care facility on 07/29/09. A review of the interagency report revealed a physician's order for Lidoderm Patches 5% to be applied to both knees bilaterally for 12 hours daily. Subsequent to the admission, Nurse E12 transcribed the physician's orders from the interagency report. During transcription, E12 inaccurately transcribed the order for the frequency of the Lidoderm Patch to read every 12 hours. Although the order was administered by the facility as intended by the physician, the inaccurate order continued to remain within the clinical record and was carried over on new physician's orders as well as the medication administration records from the pharmacy monthly. These findings were confirmed with the unit manager (E24) on 08/18/09.	F 514			

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"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 085041	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/24/2009
NAME OF PROVIDER OR SUPPLIER DELMAR NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. DELAWARE AVENUE DELMAR, DE		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
F 160	<p>483.10(c)(6) CONVEYANCE UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to convey funds within 30 days to the appropriate parties following the deaths of two (2) residents (SSR1, SSR2). Findings include:</p> <ol style="list-style-type: none"> 1. SSR1's account was opened with the facility on 11/26/01. This resident subsequently expired on 03/23/09. According to the Business Office Manager, E1 on 08/19/09, SSR1 died indigent and without a will. E1 stated the account was closed on 03/25/09 leaving a balance of \$534.01. E1 further added that the monies remained with the facility due to SSR1 being intestate and normal procedure was the facility convey's funds of expired residents that are intestate once a year to the state recovery's office. On 08/20/09, a check was written for the balance of the account and mailed to the state recovery's office. 2. SSR2's account was opened with the facility on 05/17/99. This resident subsequently expired on 02/16/09. At the time of death, \$1260.88 remained in the account that was closed on 04/02/09. The remaining funds were not conveyed to SSR2's son until 04/10/09. These findings were confirmed with E1 on 08/19/08. 			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents



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DATE SURVEY COMPLETED: 8/24/09

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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The State Report incorporates by reference and also cites the findings specified in the Federal Report.

3201 Delaware Regulations for Skilled and Intermediate Care Nursing Facilities

An unannounced bi-annual survey and complaint visit was conducted at this facility from August 17, 2009 through August 24, 2009. The deficiencies contained in this report are based on observations, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred (100). The survey sample totaled twenty (20) residents which included a review of seventeen (17) active and three (3) closed residents' clinical records. There was a sub-sample of six (6) residents for observation and interviews.

Services to Residents:

General Services:

The nursing facility shall provide to all residents the care necessary for their comfort,

The plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Delmar Nursing & Rehabilitation Center agrees with the allegations and citations listed on the statement of deficiencies. Delmar Nursing & Rehabilitation Center maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Delmar Nursing & Rehabilitation Center written credible allegation of compliance.

By submitting this plan of correction, Delmar Nursing & Rehabilitation Center does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish and standard of care, contract, obligation, or position and Delmar Nursing & Rehabilitation Center reserves the rights to raise all possible contentions and defenses in any civil or criminal claim action or proceeding.

Please cross reference F315, F323 and F365

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safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.

This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 8/24/09, F315, F323, and F365.

3201.6.2

Financial Services

3201.6.2.3

Upon the death of a resident, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.

This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L survey report date completed 8/24/09, F160.

3201.6.9

Housekeeping and Laundry Services

3201.6.9.6

The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.

This requirement is not met as evidenced by:

On 8/20/09, a check was written for the balance of the account and mailed to the state recovery office for SSR1
SSR2's funds were conveyed to SSR2's son on 4/10/09

10/19/2009

Staff has been educated on conveyance of resident funds within 30 days the resident funds and final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

Findings will be reported to the QA committee monthly and monitored therein.

Please cross reference: F469

10/19/2009



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Cross refer to the CMS 2567-L survey report date
completed 8/24/09, F469.

Medications

3201.6.11
3201.6.11.1.1

All medications (prescription and over-the-counter) shall be administered to residents in accordance with orders which are signed and dated by the ordering physician or prescriber. Each medication shall have a documented supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days. This requirement is not met as evidenced by:

Cross refer to the CMS 2567-L survey report date
completed 8/24/09, F309 and F425.

16 Delaware Code, Chapter 11, Sub Chapter II

§1121 Patient's Rights (6)

Each patient and resident shall receive respect and privacy in the patient's or resident's own medical care program. Case discussion, consultation, examination and treatment shall

Please cross reference 309 & 425

10/19/2009



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	<p>be confidential, and shall be conducted discreetly. In the patient's discretion, persons not directly involved in the patient's care shall not be permitted to be present during such discussions, consultations, examinations or treatment, except with the consent of the patient or resident. Personal and medical records shall be treated confidentially, and shall not be made public without the consent of the patient or resident, except such records as are needed for a patient's transfer to another health care institution or as required by law or third party payment contract. No personal or medical records shall be released to any person inside or outside the facility who has no demonstrable need for such records.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 8/24/09, F 164.</p>	<p>164. 10/19/2009</p>